worth noting that most studies showing brain shrinkage are in patients receiving high D_2 occupancy antipsychotic drugs, and recent unpublished longitudinal data of adult patients receiving the newer atypical drugs suggest that no shrinkage occurs over time in these patients.[11] *This raises the further possibility that much of the MRI database behind the neurodegeneration/neurotoxicity movement represents an epiphenomenona related to high levels of dopaminergic blockade and its attendant effects on cortical function. In conclusion, we would reiterate our caution to investigators and readers of this literature to suspect the improbability of the reported volume changes as being related to neurodegeneration, and we would add that the possibility that the changes reflect epiphenomena of little fundamental relevance to the primary illness is substantial at this time.*

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Posttraumatic Stress Disorder Among Criminally Involved Youth

Teplin and colleagues[1] made a methodologic advance by assembling a large sample of youth involved in the juvenile justice system to examine rates of psychiatric diagnosis. Unfortunately, their measurement overlooked posttraumatic stress disorder (PTSD), a condition that has been documented to occur at high rates among antisocial and incarcerated youth.[2-6] The absence of information on PTSD is striking given the authors' recognition that exposure to potential trauma (eg, maltreatment, neglect, and community violence) is an important risk factor for antisocial behavior and the development of psychiatric disorders.[7,8] Posttraumatic stress disorder also has clear relevance for their findings that show substantial depression, dysthymia, and substance abuse in the sample, as well as their recommendations regarding future research on patterns and sequences of comorbity. Epidemiologic evidence demonstrates that PTSD is accompanied by high rates of comorbid affective and substance use disorders, and suggests that exposure to traumatic stressors and development of PTSD often precedes the onset of these comorbid conditions and may be risk factors for them.[9-11] While the findings and recommendations by Teplin and colleagues stand on their own merits, they are limited to the extent that trauma and PTSD are major features of the lives of the young people they studied. We strongly encourage future researchers to include evaluation of exposure to trauma and PTSD so that a more comprehensive understanding of the mental health needs of criminally involved youth will emerge.

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In reply

We agree with Drs Kaloupek and Newman. Posttraumatic stress disorder is an important disorder to assess. Unfortunately, our instrument, the Diagnostic Interview Schedule for Children (DISC) 2.3, did not include a module on PTSD.

The DISC-IV PTSD module became available 13 months after our study began; thus, we could assess PTSD in only 898 of our 1829 subjects.

We had considered including PTSD in the article. However, we decided to exclude it for 3 reasons:

- *(1) Lack of comparability. The DISC-IV PTSD module generates diagnoses within the past year; the DISC 2.3 generates diagnoses within the past 6 months.*
- *(2) Clarity. Because we assessed PTSD in only a subsample, the tables would be confusing to the reader. Our tables had included the summary categories, "any of the listed disorders" and "any except conduct disorder," which presume that diagnoses are available for all cases.*
- *(3) Depth. The importance of trauma and PTSD in our sample warranted a more detailed presentation and discussion than could be included in the article. Our findings on the history of trauma, type of trauma, and PTSD will be presented in a separate article.*

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Relapse in Bulimia Nervosa

The report by Halmi and colleagues[1] on "relapse" in bulimia nervosa is of considerable importance since it raises serious doubts about the clinical value of cognitive behavior therapy (CBT), the leading evidence-based treatment for this eating disorder.[2] The finding of note is that 44% of those participants with an excellent posttreatment outcome (total remission from binge eating and purging) relapsed within just 4 months of completing treatment. However, we suggest that to interpret this observation, 2 points need to be clarified.

The first point concerns the clinical significance of these relapses since no explicit definition was provided in the report. It is essential to know what thresholds were used to define relapse. Did all of these participants develop an eating disorder of clinical significance, or were subclinical symptomatic states also classed as relapses? Also, do the authors know whether these relapses persisted or might they have been temporary setbacks?

The second point centers on an important piece of complementary information needed to put the findings in context. Five previous studies have found that the proportion of patients who respond to this form of CBT is relatively stable following treatment.[3-7] Was this also true in the present study? In other words, was the rate of relapse matched by an equivalent rate of remission among those participants who were not yet fully asymptomatic at the end of treatment, as was recently demonstrated in a large multicenter trial that used the same treatment and assessment methods?[7]

Halmi and colleagues do not comment on the potentially serious implications of their findings for the clinical utility of CBT. We suggest that in the absence of the additional information specified above their clinical significance cannot be determined.

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In reply

We welcome the opportunity to clarify the interpretation of our study of CBT for bulimia nervosa. This study was designed to identify those patients who responded especially well to CBT (complete abstinence from bingeing and purging) but who might benefit from additional follow-up support to consolidate their improvement. To do this, we employed a highly sensitive definition of "relapse" to mean no episode of bingeing or purging whatsoever in the month prior to the 17-week or 4-month posttreatment interview.

As Fairburn and Cooper point out, however, our article could be misinterpreted as a study of clinical relapse, thereby casting doubt on the value of CBT. This is not the case, and the following data should make this clear:

- *In our study, we focused only on the 48 patients who had a complete response to CBT within the 20 weeks of treatment (ie, they were totally free from bingeing and purging from week 16 onwards).*
- *At the time of the 17-week posttreatment evaluation, 5 of the 48 patients met criteria for bulimia nervosa, and 7 others fell into the category of eating disorders not otherwise specified. Thus, only 12 patients (25%) were clinically impaired. This means that 75% of those patients who had responded to CBT with complete abstinence were actually doing very well and were free of a clinically significant problem. At a 34-week posttreatment assessment, only 6 patients were identified as having a clinically significant eating disorder.*